REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT Michigan Department of Human Services

Was complaint phoned to DHS?					
Yes No If yes, Log	<u> </u>		o, contact the local DHS		у
INSTRUCTIONS: REPORTING PERSON: Complete if applicable). Send PART 1 to local County DHS whadditional instructions on back.	ere the child is fo	ound. Retain PART	2 for your records. Se	onnel, 1. Date	
2. List of child(ren) suspected of being abused or neglected	d (list additional chi	1	1	l 05v	
NAME		BIRTH DATE	SOCIAL SECURITY #	SEX	RACE
3. Mother's name					
4. Father's name					
5. Child(ren)'s address (No. & Street)		6. City	7. County	8. Phone No.	
		o. ony		0.1.1.01.0.1.0.1	
9. Name of alleged perpetrator of abuse or neglect		10. Relationship to child(ren)			
44 December 4 the children's living with when the colored account		12. Address City 9. 7in Code where abuse/paging accurred			
11. Person(s) the child(ren) living with when abuse/neglect occurred		12. Address, City & Zip Code where abuse/neglect occurred			
13. Describe injury or conditions and reason for suspicion of abuse or neglect (Attach additional sheets if necessary)					
		· 			
14. Source of Complaint (Check appropriate box)		☐ PSYCHOLOGIS	et 🗆	CLERGY	
PHYSICIAN/PHYSICIAN'S ASSISTANT AUDIOLOGIST		PROFESSIONAL COUNSELOR MARRIAGE/FAMILY THERAPIST			
MEDICAL EXAMINER (Coroner) *SOCIAL WORKER		☐ TEACHER ☐ DHS FACILITY ☐ LAW ENFORCEMENT OFFICER ☐ DCH FACILITY			
	ADMINISTRATOR COUNSELOR	CHILD CARE P	<u> </u>	DCH FACILITY ELIGIBILITY SPE	CIALIST
EMERGENCY MEDICAL SERVICES PERSONNEL	HOSPITAI	_		CIAL WORK SPE	
FAMILY INDEPENDENCE MANAGER	=	NDEPENDENCE SPE	_	CIAL SERVICES	
SOCIAL WORK SPECIALIST MANAGER DOMESTIC VIOLENCE PROVIDER		E SERVICES SPECIA OF THE COURT	LIST Uth	er (Specify below)	
15. Reporting person's name 16. Name of reporting organization (school, hospital, etc.)					
17. Address (No. & Street)		18. City	19. State 20. Zip Co	de 21. Phone	No.
TO BE COMPLETED BY MEDICAL PERSONNEL WHEN PHYSICAL EXAMINATION HAS BEEN DONE					
22. Summary report and conclusions of physical examination			LEXAMINATION	IAO BELIT BO	/IVL
	•	,			
		Tarva			
23. Laboratory report		24. X-Ray			
25. Other (specify)		26. History or physical signs of previous abuse/neglect			
		☐ YES ☐ NO			
27. Prior hospitalization or medical examination for this chil	d	-			
DATES		PLACES			
28. Physician's Signature	29. Date	30. Hospital (if appl	icable)		
Department of Human Services (DHS) will not discriming	l nate against anv	individual or group			
because of race, religion, age, national origin, color, heig orientation, gender identity or expression, political belief	ht, weight, marital	status, sex, sexual	AUTHORITY: COMPLETION	P.A. 238 of 1 : Mandatory.	975.
reading, writing, hearing, etc., under the Americans with D	isabilities Act, you	are invited to make	PENALTY:	None.	
your needs known to a DHS office in your area.		J			

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INSTRUCTIONS

GENERAL INFORMATION:

This form is to be completed as the written follow-up to the oral report (as required in Sec. 3 (1) of 1975 PA 238, as amended) and mailed to the local county Department of Human Services. Indicate if this report was phoned into DHS as a report of suspected CA/N. If so, indicate the Log # (if known). The reporting person is to fill out as completely as possible items 1-21. Only medical personnel should complete items 22-30.

- 1. Date Enter the date the form is being completed.
- 2. List child(ren) suspected of being abused or neglected Enter available information for the child(ren) believed to be abused or neglected. Indicate if child has a disability that may need accommodation.
- 3. Mother's name Enter mother's name (or mother substitute) and other available information. Indicate if mother has a disability that may need accommodation.
- 4. Father's name Enter father's name (or father substitute) and other available information. Indicate if father has a disability that may need accommodation.
- 5. Child(ren)'s address Enter the address of the child(ren).
- 6. City
- 7. County
- 8. Phone Enter phone number of the household where child(ren) resides.
- 9. Name of alleged perpetrator of abuse or neglect Indicate person(s) suspected or presumed to be responsible for the alleged abuse or neglect.
- 10. Relationship to child(ren) Indicate the relationship to the child(ren) of the alleged perpetrator of neglect or abuse, e.g., parent, grandparent, babysitter.
- 11. Person(s) child(ren) living with when abuse/neglect occurred Enter name(s). Indicate if individuals have a disability that may need accommodation.
- 12. Address where abuse / neglect occurred.
- 13. Describe injury or conditions and reason of suspicion of abuse or neglect Indicate the basis for making a report and the information available about the abuse or neglect.
- 14. Source of complaint Check appropriate box noting professional group or appropriate category.

Note: If abuse or neglect is suspected in a hospital, also check hospital.

DHS Facility - Refers to any group home, shelter home, halfway house or institution operated by the Department of Human Services.

DCH Facility - Refers to any institution or facility operated by the Department of Community Health.

- 15. Reporting person's name Enter your name if you are reporting this matter.
- 16. Name of reporting organization Enter the name of the agency or organization, if appropriate.
- 17. Address
- 18. City
- 19. State
- 20. Zip Code
- 21. Phone Number